Optometry Coding & Billing Alert

Cover All Your Documentation Bases for a Reimbursement Home Run

Before you use modifier -25 to file for reimbursement for an E/M and plug insertion, make sure your claim separately identifies the two services.

For hassle-free -- and denial-proof -- modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or service) use, follow these expert billing rules:

1. Documenting Each Procedure Is Key

All carriers require clear documentation that the optometrist rendered a significant, separately identifiable office visit. An excellent way to achieve this is to separate the documentation for each procedure, says **Janine George**, office manager for Mallinger & Eger Optometric Associates in Pittsburgh.

Page 1 -- Visit Documentation. At a minimum, this documentation should incorporate the patient's chief complaint, history of present illness, review of the system of complaint and any related system examination and medical decision-making documenting the physician's impression and treatment plan.

Page 2 -- Minor Procedure Documentation. Be sure the doctor includes the patient's name, date, type of procedure and instrumentation, medications or anesthetics used. Don't let the optometrist get away with briefly documenting the procedure in the E/M report -- the carrier will not consider this sufficient documentation for separate reimbursement. A separate form titled "Operative Report" is very helpful in documenting the two different procedures, says **David Gibson, OD, FAAO,** practicing optometrist in Lubbock, Texas.

Be Proactive. Unless you file claims electronically, consider sending the carrier the documentation for both services as soon as you submit the claim, George says. You will avoid delays that might surface if the carrier decides it is necessary to review the documentation before separately reimbursing each service. If the carrier denies the two separate procedures, use your documentation to appeal the claim.

Avoid. Don't append modifier -25 just because you documented "visiting with" or "speaking to" a patient before a procedure. To bill with modifier -25, make sure the E/M service can stand alone as a distinct procedure.

2. Linking Pertinent Diagnoses Is a Must

Link the diagnosis code for the sign or symptom that brought the patient to the office to the E/M service. Link the diagnosis code for the condition the physician found and treated to the minor procedure. Based on these requirements, you may be able to link the same diagnosis code to each service -- and in certain situations, this is correct coding.

CPT states that an E/M service may be prompted by a symptom or condition that requires a procedure but that the procedure must be separate from any procedure your physician completed for the initial symptoms or conditions. You don't necessarily have to have a separate diagnosis to have a separate procedure.

Justifying use of modifier -25 -- and separate payment for each service -- is easier, however, when you can link each code to a separate diagnosis, Gibson says. "In the best case, for example, you would have two possible causes for the itch and burn, such as blepharitis or an allergy, to treat in addition to dry eye."